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M e m o r a n d u m

To: Fredrick Bechtold, Administrator
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Date: April 19, 2011

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On March 22 & 23, 2011, the Operation Guardians team conducted a surprise inspection of Desert Knolls Convalescent Hospital in Victorville. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. The review of the medical record of Resident 10-05-01 indicated she had been admitted for hospice services August 2010. There were no physician facility orders for hospice and no Care Plan indicating hospice care. There was no chart documentation indicating there was communication occurring between the facility and the Hospice agency delegating the responsibilities of the care providers. According to the resident's Advanced Directive, she did not want to receive antibiotics or hospitalization. On March 10, 2011, antibiotics were ordered and administered for 14 days.

   The resident was observed awake, alert, lying in bed watching television. She was able to direct her care and assist with her activities of daily living. She required medication for pain and anxiety and was receiving wound care treatment for a re-opened stage II coccyx pressure ulcer. It was unclear to the team how Hospice services were benefitting the resident in her current medical state, as it appeared the resident was receiving Comfort Care measures.

2. The review of the wound log for Resident 10-05-02 indicated he had an ulcer to his right heel. There was no staging documented on the wound care sheets- only a mention of a 7.0 cm broken blister. The team nurses observed the resident's right heel wound which showed an approximate 7.0 x 8.0 cm circular wound that had clearly been a blister. The treatment nurse was questioned why the facility was not staging the wound for the appropriate treatment. The wound nurse indicated she was trained by the facility "*not to stage wounds on a diabetic resident because the wound would be considered a diabetic ulcer and not a pressure ulcer."*

   The resident's right foot did not appear to have obvious structural foot deformities or peripheral vascular skin changes that can occur in residents with diabetes. There was also no skin redness, scrapes, cuts, or callus tissue. According to the "Podiatric Evaluation & Treatment Document," dated February 15, 2011, the neurological sensation was noted to be normal. Since most diabetic ulcers occur on the bony prominences of the foot, the resident's heel ulcer was most likely caused by pressure or shear. The heel ulcer should then be considered a facility acquired pressure ulcer, documented and treated as such. The pressure ulcer likely occurred from a deep tissue heel

injury. This resident may benefit from floating his heels off the bed surface by placing a pillow under the calf of each leg.

3. Resident 10-04-03 was observed sitting in bed and appeared alert, talkative and able to direct her care and needs. The OG team asked her why she was at the facility and she replied that her son had dropped her off at the local hospital and she was sent here instead of back to her son's home where she had been living. She became very tearful discussing what would happen to her if her son would not allow her to return home with him. The resident stated she was able to take care of herself maintaining she did not need assistance eating, bathing or going to the bathroom.

   There was a piece of paper taped to the resident's bed table stating "fluid restriction". It was noted she did not have a water pitcher or glass at her bedside. There was no information at the bedside indicating how much fluid she was allowed to consume in a 24- hour period. The team asked the resident why she was on a fluid restriction and she stated she did not know and reported she was only provided fluids with her meals.

   The resident's medical record was reviewed, and there was a physician order for fluid restriction; however; there was no indication in the order why the restriction was necessary. The face sheet lacked a medical diagnosis. The OG nurse was only able to locate the resident's diagnosis from a recent hospital History and Physical (H&P). There was no diagnosis listed in the H&P that would indicate she required a fluid restriction.

   The care plans were reviewed and there was a care plan for fluid restriction but it did not give a reason for the fluid restriction. There appeared to be conflicting care plans stating she was "at risk" for dehydration and she "required fluids to be encouraged." During an interview with the Director of Nursing (DON) she was asked why this resident was on a fluid restriction. She replied "*the resident had congestive heart failure (CHF) and her son did not want her to know about the diagnosis."* The team reported to the DON the resident's chart lacked a diagnosis for CHF. It should also be noted the resident was her own responsible party.

4. On March 22, 2011, an OG nurse observed the dressing change of Resident 10-05-04. The treatment nurse reported the wound was an excoriation of the lower gluteal cleft. However, when the dressing was removed, the wound did not appear to be an excoriation. The wound size had increased from 1.1 by 2.0 cm and 0.4 cm deep as last documented on March 17, 2011 to approximately 5.0 by 3.0 cm with an undetermined depth. The depth was undetermined as the wound bed was covered with approximately 50% yellow slough (dead tissue). The wound, on examination, appeared to be a **Stage III** pressure ulcer as it had full thickness skin loss and slough or dead tissue in the wound bed. The facility's CWS (certified wound specialist) reported to the OG nurse she was still determining the wound to be an excoriation because it started by the resident having frequent incontinent stools. She suspected the stool PH was altered by the resident's cancer.

   According to facility documentation, the resident's wound dressing was last changed on March 20, 2011 and the treatment nurse failed to update the "Skin/Wound Progress Report." This report is required to be completed on a weekly basis and when a wound condition worsens. By the facility treatment nurses not updating this sheet, it was difficult to tell how fast the wound had deteriorated and if the appropriate treatment changes should have been made to the resident's

care. The facility's inaccurate documentation of the resident's wound may be preventing the resident to receive the correct wound care treatment. This could possibly be considered a neglect issue.

The resident was observed on a low air loss mattress but there were layers of linen between the resident and the mattress. Also, the resident may not have been turned as frequently due to the wound being described as an excoriation and not connected to possible pressure.

5. The resident residing in room 26 A was observed sleeping supine in his bed. He was lying on a pressure relieving mattress and upon inspection it was noted the mattress control was not working. The team nurse requested the assistance of a facility licensed nurse to investigate why the mattress was not functioning. Upon further investigation, the facility nurse determined the mattress had not been plugged into the electrical wall outlet. It was unclear how long the resident had been lying on a non-pressure relieving surface.

6. The resident residing in room 66 B was observed up in a Geri-Chair. It was noted he was unable to move his left arm or leg. The Geri-Chair was positioned at the bottom and left side of the foot of the bed, not facing the bed but facing the far wall of his room. The call light was observed positioned behind the Geri-Chair and on the left bottom side of his bed. The call light was not available for the resident's use.

7. The resident residing in room 58 A was observed with poor oral hygiene. Her teeth were caked with a whitish yellow colored substance. The resident acknowledged the staff was not routinely brushing her teeth. Her call light was also out of reach. These observations could indicate facility neglect.

8. The call light for the resident in room 16 B was stuck between the mattress and bed rail and the resident could not locate the call light when asked where her call light was. This resident requested to get up in a wheelchair when we were doing our walk though of the facility. The team did not see the resident up in a wheelchair until the following day March 23, 2011.

9. During resident interviews in the facility, the team was informed by two residents that it the afternoon shift routinely takes a long time to answer their call lights.

10. The medical record review of resident 10-05-05 showed two different Desert Knolls Convalescent Hospital Interdisciplinary Team Physical/Chemical Restraint Assessment & Consent forms for the utilization of a soft belt while the resident was in bed. One form was dated May 3, 2010 and the other form dated May 25, 2010. The forms gave no indication why the soft belt was required when the resident was in bed. The forms also indicated a resident's family member gave "verbal" consent for the restraint. At the bottom of the form it read "Please see Resident Plan of Care."

    The review of the resident's Care Plan did not include a nursing plan/approach for the soft bed restraint. It should also be noted the facility's monthly physician orders did not include an order to utilize the soft bed restraint. The CNAs assigned to the resident's unit confirmed with the OG nurse the soft belt restraint was being applied on the resident during the night because she would remove the resident's soft belt when she came onto her shift in the morning. This is a violation

of Title 22, §72528. Informed Consent Requirements.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. A small spiral notebook with handwritten resident names and room numbers was observed on a bed side table in the facility's hallway. A staff person witnessed the team finding the notebook and immediately took the booklet and placed it in her pocket. The residents' privacy had been violated by the employee.

2. The Oxygen Room located by the Rehabilitation Room was observed with dirt particles on top of a white lid attached to a storage bin stored on a shelving system.

3. The Entech Room located by the Rehabilitation Room contained an exit door leading to the outside of the building. There was an approximate 0.5 inch space surrounding the door knob that required sealing. The space around the door knob could allow flying insects to enter the storage room. This is an infection control issue.

4. The Utility Room at Nursing Station II was observed with several shower chairs lined up against the counter on the clean side of the room. An employee was asked if the chairs were clean and she replied "*No, they are not clean*." The chairs would best be stored in the room in a designated area other than being placed against the counter of the clean equipment area. This is an infection control issue.

5. The Housekeeping Chemical Storage room's door handle was locked but the door was not closed securely. This is a safety issue for facility residents that wander.

6. The majority of the residents were eating breakfast in their rooms. Many of the residents were observed inappropriately positioned in their beds making it unsafe to eat from the trays. Several of the rooms were very dark, making it impossible for the residents to see their food. It was unclear why the residents were not up and in the dining rooms for the meal. When several of the residents were questioned about this practice, they said they were not asked if they wanted to go to the dining room and didn't know they had a choice

7. On both days of the inspection, residents were observed in the Activity Room waiting for more than one hour for their lunch to be served. The residents were observed sitting in wheelchairs with bibs on becoming restless and agitated with the prolonged wait. It was not clear why the residents were not given something to do during this time to make the wait more comfortable.

8. While observing a resident's wound in Room 3B, it was determined the bed was too antiquated to be utilized for resident care. The Certified Nursing Assistant (CNA) was unable to raise the bed by the hand crank to the appropriate height for wound care treatment. The resident was in need of a newer bed suited for optimum resident care.

9. The insulin for the resident in room 36A was sitting on top of the medication cart in front of Room 38. The medication nurse was not within site of the cart.

10. The bathroom in Room 34 had a urine soaked blue chux lying outside of the trash receptacle. The odor was so strong that the bathroom could not have been utilized.

11. The call light for the resident in Room 16B was observed between the bed rail and mattress. She was not able to call for assistance as needed.

12. The side rails for the resident in Room 37 B were covered with a type of tube foam covering, however; it did not fit well and the metal part of the side rail was uncovered. This was a safety hazard.

13. The hallway exit by Room 33 was blocked by a wheelchair and a cleaning cart.

ADMINISTRATIVE OBSERVATIONS:

1. The facility's infection control documentation of maintaining, reviewing, and reporting statistics of the number, types, sources, and locations of infections within the facility was not provided to the team as requested. Because of this action, it could not be determined if the facility was maintaining the appropriate health and safety procedures as required by state regulations.

2. While observing the treatment nurse perform several residents' wound care, it was determined the lighting in the residents' rooms was insufficient. This impacted the nurse's ability to perform precise wound observations and measurements.

3. It was noted a large majority of the facility's resident population was receiving oxygen therapy by nasal canola. Review of several of the resident's physician orders indicated the oxygen was to be administered as needed (PRN). There were no physician orders or nursing documentation indicating oxygen saturations were to be monitored or the residents had symptoms requiring the administration of oxygen therapy. The facility's "Policy and Procedure for Oxygen Administration" was reviewed and it was determined the facility was not following Respiratory Care- Oxygen Therapy policy. It was unclear what criteria the facility was utilizing for the safe administration of oxygen.

4. Review of the facility's Resident Abuse Investigation Policy and Procedures showed the policy was not in compliance with California State law. Individuals that witness or suspect abuse or neglect are required to fill out the SOC 341 form, not the Administrator. An individual facility's investigation into possible abuse is completely separate from what is required under California law. Any employee of a facility can be charged with a "failure to report" for failing to follow this law. We would suggest that the administrator and staff review the Department of Justice mandated training materials and video entitled "Your Legal Duty: Reporting Elder and Dependent Adult Abuse."

STAFFING:

Based on the February 2011 records provided by the facility, (staffing records were not provided for the first two weeks in March 2011 as requested by the team), staffing levels were above the 3.2 hours per resident day (hprd) on four of the four days randomly reviewed for February 2011.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to, Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913.